STATE OF CALIFORNIA

CLINICAL SOCIAL WORKER EXPERIENCE VERIFICATION

1800 37A-201 (REV. 8/06)

BOARD OF BEHAVIORAL SCIENCES
1625 NORTH MARKET BLVD., SUITE S200, SACRAMENTO, CA 95834
TELEPHONE: (916) 574-7830 TDD: (916) 322-1700
WEB SITE ADDRESS: http://www.bbs.ca.gov

The supervisor must complete this form. Use a separate form for each person verifying hours of supervised experience in a clinical setting for licensure as a clinical social worker and for each employment setting. ***Make certain that the form is complete and correct prior to signing. Any change should be initialed by the supervisor and is subject to verification.*** *Experience verification forms are to be submitted by the applicant with his or her application for licensure.*

APPLICANT NAME: _____

I. SUPERVISOR: (*Please type or print clearly in ink.*)

1. SUPERVISOR NAME: Last First Middle

2. ADDRESS: Number and Street

City	State	Zip Code

3. BUSINESS TELEPHONE:

4. NAME OF APPLICANT'S EMPLOYER:

5. ADDRESS: Number and Street

City	State	Zip Code

6. BUSINESS TELEPHONE:

7. Experience was gained in a setting that lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy? Yes ☐ No ☐

8. Experience was gained in a setting that provided oversight to ensure that the associate's work meets the experience and supervision requirements and is within the scope of practice for the profession? Yes ☐ No ☐

9. Dates the experience is being claimed: From _____ (Mo Day Yr) To _____ (Mo Day Yr)

10. Total number of supervised weeks worked: (minimum 104)

    a. Total number of hours in individual supervision: a. _____

    b. Total number of hours in group supervision: b. _____

11. Total number of hours worked per week (maximum hours 40): _____

12. Total number of hours in clinical psychosocial diagnosis, assessment, including individual or group psychotherapy/counseling: (minimum hours required 2,000) A. _____

    Total number of face-to-face individual or group psychotherapy/counseling: A1. _____

    (minimum hours required 750)

    Total number of hours in client-centered advocacy, consultation, evaluation, and research: (maximum hours 1,200) B _____

    Total number of hours of experience: (minimum hours required 3,200) A + B = C **C.** _____

13. One hour of face-to-face individual or two hours of face-to-face group supervision was given for every week in which more than 10 hours of face-to-face psychotherapy was performed? Yes ☐ No ☐

14. SUPERVISOR: _____ (Type of License) _____ (License Number) _____ (State of License) _____ (Date Originally Licensed)

If M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision?
Yes ☐ No ☐ Date Board Certified: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ (Date) _____ (Signature)